

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046145

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11200

STATE FILE NUMBER

FILED NOV 22 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

c. CITY

St. Louis

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION

Homer G Phillips

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

2307 Hickory

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED

(Type or print)

First

Sylvester William

Middle

Turner

Last

4. DATE OF DEATH

Month

11

Day

8

Year

63

5. SEX

Male

6. COLOR OR RACE

Negro

7. Married ☐ Never Married ☐

Widowed ☐ Divorced ☒

8. DATE OF BIRTH

1/2/98

9. AGE (last birthday)

65

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Molder

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (City and state or country)

Wolf Island Mo.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Porter Turner

13b. MOTHER'S MAIDEN NAME

Mary Ann?

14. NAME OF HUSBAND OR WIFE

Divorced

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Maggie Daquess 4631 St. Ferdinand

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Mysocarditis
Hepatitis

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐

NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 8:15 P. to and last saw her alive on Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE

(Degree or title)

Helen L. Taylor, Coroner

22b. ADDRESS

1300 Clark Ave.

22c. DATE SIGNED

11-12-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

11/14/63

23c. NAME OF CEMETERY OR CREMATORY

Father Dickson

23d. LOCATION (City, town, or county)

St. Louis County Mo.

24. FUNERAL DIRECTOR

ADDRESS

Grant Johnson 2615 Marcus Ave.

25. DATE RECD. BY LOCAL REG.

NOV 12 1963

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

H. C. Lande Gordon

Licensed Embalmer No.

3489

P. O. Address

1123 N. Taylor

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.